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THE HUNDRED-DAY HATE-IN

A stubborn attempt at staffless milieu therapy

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INTRODUCTION

The Oak Ridge or Maximum Security Division of the Penetang Psychiatric Hospital receives patients from the Courts, Reformatories and Penitentiaries, and other Ontario Psychiatric Centres. Generally, they constitute a group that cannot be safely treated elsewhere because of the seriousness of their legal situations or the presumed dangerousness of their psychiatric state. Intensive treatment programmes for these patients begun in 1965, rested on the philosophy that a genuine encounter between persons in the terms of Martin Buber's "turning towards" was the aim and achievement of therapy. In Buber's words:

"The basic movement of the life of dialogue is the turning towards the other...Genuine dialogue ---no matter whether spoken or silent---where each of the participants really has in mind the other or others in their present and particular being, and turns to them with the intention of establishing a living mutual relation between himself and them".

After two years' development with 150 patients in four therapeutic communities, a type of milieu therapy has evolved which places heavy emphasis on the use of patients as therapists in lengthy and intensive programmes of small groups, committees, and ward meetings. On one ward this operates at a level of 80 hours per week. These communities function on an almost staffless basis that frees them from dependence on professional staff resources except for the use of medication. This emphasis is in part the upshot of theoretical convictions,

and partly a necessity forced by Oak Ridge's chronic professional staff shortage. A battery of drugs -- scopolamine, methedrine, tofranil - dexamy, and dexedrine fuel the already anxious and emotional atmosphere of the two units to a point where 5 to 10 patients are always upset enough to warrant round - the - clock observation. In our opinion, such disruption of deeply - entrenched defences makes good sense for patients in Oak Ridge, where anything short of a personality - change may mean life long incarceration.

Several concrete advantages have resulted from the programmes that have been developed. The morale of participating patients has risen considerably, and this has resulted in reducing the security risk of escape. The administrative burden on the hospital staff has been reduced by the skill which intelligent and generally well preserved patients bring to their new found positions of responsibility -- recommending medication changes, preparing progress charts assessing new admissions, and caring for upset fellow patients. But most of all, compared to the staff and inmate sub-culture of a prison, these patients are at least not now lounging through a perpetual coffee break, colluding in one another's fantasies and denials, and swapping lies about past or planned anti-social acts.

Over a year ago however it became clear that two main problems dictated the need for further changes.

In the first place, ~~anxiety-raising procedures~~

may be good treatment from the point of view of personality change, but the risks of homicide and suicide become very real in such a programme, and in the conventional Oak Ridge ward such patients have relatively easy access to steal bedsprings, glass coffee jars, sheets, chairs, forks, and spoons -- a veritable armoury for anyone keen to act out on himself or someone else. In short, as the level of anxiety continues to escalate on the units, it becomes more and more likely that the elaborate system of safeguards and observers might fail.

Secondly, a problem of quite a different sort, and one that has been reported in the literature is the phenomenon of patients, usually psychopaths, rising to the organizational apex of a therapeutic community without being touched by the treatment programme. In our hospital some of these patients have spent as much as two years perfecting the slick expertise of the professional therapeutic community patient. Slick, articulate and well versed in the defensive psychologies that can cover the most radical conflicts by describing them impressively, they had become accustomed to operating with a minimum of discomfort in the highly-structured programmes on the Milieu Therapy wards developed until last year. Intellectually, however, many of these patients have learned that they are indeed sick, and that the way out--is to get well. It is these patients, who regard the overcoming of their pathologies as an obstacle course or problem, that are keen to team up with professional staff to make use of as many resources as can be made available to

~~solvent the dilemma~~ It is these patients, who told us that as long as they could retreat to the privacy of their own room at night, or escape with books or T.V., that even a 100 hour a week programme would still leave them unscathed. It was these patients, who realized that confrontation would be inescapably intense if each was in the physical presence of all others continuously for long periods of time. In October, 1967, therefore, a special unit was opened with the dual purpose of involving patients who had been resistant to other forms of therapy, and at the same time increasing the safeguards against homicide and suicide. Both these objectives were achieved in a way that was simple, direct, and logical, but at the same time quite capable of being described, as it was by the father of one of our patients, as "a set-up worse than Auschwitz". In some ways it did appear as the antithesis of psychotherapy.

Each of the 38 bed wards in Oak Ridge has attached to it a so-called "sunroom", a room about four yards by twenty, usually equipped with a television set and used by the patients to lounge in their free time. [One of these rooms, with its barred and safety screened windows, constituted ~~that~~ physical setting for the Compressed Encounter Therapy unit. Everything was removed from it. There were no books, no furniture, (the patients sat on cushions or on the floor), no radio, no T.V., no magazines or pictures, no tobacco—nothing that could even remotely serve either as a distraction or a weapon. Letters, visits, and talking to attendants was discouraged. The patients ~~never left the room~~ except for

emergency dental or x-ray care. No periods were spent outside in the fresh air, exercise was restricted to 5BX in the room. There was no clock and no calendar. No tranquilizers or sedatives were given. Food was served on paper plates, eaten with paper spoons, and pushed through a slot in the locked grill gate. Patients sat or lay on the floor except at night when they slept on mattresses with ~~unremovable~~ blankets that were put into the room at 10:30 p.m. and taken out again at 7:00 a.m. Staff observed on a CCTV screen all night, and when the patients slept it was under bright lights, observed by two patients who kept awake on dexedrine. Each patient was in the direct physical presence of the entire group all the time: eating, walking, talking, sleeping, sweating, defaecating, playing — with no retreats into physical solitude or violence possible.

COMPOSITION

Patients entered the unit on a voluntary basis, completing a written "contract" in which they recognized that the tensions of living under such circumstances would soon create pressures in them to leave, but left the decision about the time of their departure to the staff. No amount of contract signing however, would have stemmed the tide of demands, pleas, threats, cajolements, and manipulations that rose and continued unabated after the third or fourth day of each group in attempts to get out.

The first group had 16 members, and stayed

continuously in the room for 100 days. The second and third groups were similar in size, but of only 40 days duration. The final eight-member group underwent a 50 day experience. Many patients stayed for more than one group, and two patients remained in the unit continuously for six months. A total of 44 patients were involved, half of whom were schizophrenics, half psychopaths. All had at some point been convicted of, or charged with, criminal offences, ranging from break enter and theft, through arson, rape, possession of a deadly weapon to murder. Of the total group, one third had killed.

The moves made to reduce the risk of suicide and homicide are fairly obvious -- the removal of all potential weapons and the continual physical presence of a group large enough and willing enough to intervene if violence occurred.

To help solve the second of the two main problems referred to earlier, the problem of the slick psychopath who could manipulate his way through the elaborate structure of our therapeutic community wards, our plan was to demolish all formal social organization and to encourage the challenging of all the fixed assumptions about sickness and health that the discipline of our traditional therapeutic communities rests upon. In this connection we felt with Laing (11) that psychotherapy "consists in the paring away of all that stands between us, the props, masks, roles, lies and defences, that we use by habit and collusion, wittingly or unwittingly, as our currency for relationships". In an attempt

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to start things off in this direction the patients were exposed to Human Relations Training literature aimed at focusing their attention exclusively on "here-and-now" phenomena, and specifically upon the concept of feedback as it is practiced in T-Group sessions. It was our hope that removing all the props for mystifying social rituals would help patients to grapple with the real emotional issues between them.

But powerful fantasies of the riot and disorder that might accompany any lessening of the traditional formal social structure, haunted many of the attendants, and made it unfeasible to de-structure quickly. Let me quote from the report book kept by the attendants:

"All patients milling around in the sunroom.
playing with a button on a string.
1:30 p.m.: Patients quiet, mainly lying around
and appear to be sleeping...2:30: a few
patients sleeping, others standing at the grill
gate, watching the plumbers. Patient
exercising quite a bit through the afternoon...
killing flies by strangulation with
pieces of thread".

And again:

"Patient very paranoid about the group,
especially 1 and He says
he feels the group is hiding something from him.
The patient is becoming quite upset.
trying to talk to him. There
seems to be a lot of fear building up. No one
seems really concerned about , just fear-
ful of what he might do while he is paranoid".

In point of fact, through the whole eight month operation of the programme there were only four outbreaks of physical violence, all of which were stopped immediately by other patients and none of which led to serious injury. But it was not until patients began to lie down and sleep within the structure of a planned programme, and the attendants found no way of coercing them to stay awake ("but what can we deprive them of?" "0), that they agreed to the ~~complete~~ destructuring of the final group -- that is, no organized programme was required or expected.

In each case, the indication for terminating the group was a stage where communication on a genuine emotional level was decreasing. The administration of the defence disrupting drugs scopolamine and methedrine frequently would reshuffle what was becoming a fixed pattern of communication, but for all groups, entropy seemed in the end to lie in the direction of a reduction of interaction.

Let me quote again from the attendant record book:

"Patient was wondering why the group wasn't asking why he punched out windows when he went for an x-ray, and what was bothering him. Silence prevails".

What were the effects of this programme? Let me read some quotations from the very extensive questionnaires and essays which were completed by all patients once weekly while in the sunroom, immediately after leaving, and again three weeks later.

The Compressed Encounter Therapy Unit fell from within; the destructive element was the attitude of the individual patients. "If they don't do it, why should I?" was the sort of thing. Everyone was waiting for someone else to get the ball rolling again, but how could that happen when everybody was thinking the same thing: "If they won't try, why should I?" (Patient's account).

"People realized what they had to do to get better and weren't prepared to do it, or couldn't do it, or weren't motivated to do it, or something like that. People just didn't want to go to people...it just had to end". (Patient's Account).

"I found it to be very uncomfortable and on a few occasions almost unbearable because I could see that no one really gave two fucks about me, or I for them, for that matter". (Patient's account).

"I'm afraid to face the weakness I've been confronted with inside myself. I think I've been laid bare and stretched out for the ants". (Patient's account)

"I'll shine peoples' shoes, but I can't love them." (Patient's account).

"I expressed my needs, and as I did so my friends retreated, and I discovered I could not hold them nor offer them myself, and so I too retreated and isolated myself, my fears

and needs from them, and decided to fulfil my commitment without them. This of course is impossible. My self-centredness was so high, I had nothing of real value to offer, or at least I did not believe so. The trap I fell into is obvious to the wise and healthy, and defies description here. I was sitting down when I should have been standing up".
(Patient's account).

However, in all groups, while indifference and hate were the emotions most frequently expressed at the middle of the group's development, and almost exclusively at the end of it, the retrospective reports of the group members suggested that this atmosphere was more magnetic in its way, than the more "positive" atmosphere of the regular milieu therapy wards.

"When I came out of the sunroom I felt an urge to say to the staff to forget the whole thing, and run back into the sunroom".
(Patient's account).

"I have lived in this setting only three short months, but looking back, I would say that here were the experiences of a lifetime concentrated into an all-too-short period". (Patient's account).

It appeared that the tremendous tension sharpened the awareness of patients that they needed one another's positive feelings. While this smacks a little of saying that gas chambers are good insofar as they remind us of our need for fresh air, it is a fact that patients transferred to other wards spoke sincerely of what had happened in the Compressed Encounter Therapy Unit as a more direct, honest and uncluttered mode of communication.

"I feel that the only thing the experience harmed was my false ego...it showed me some things about myself I didn't know before".
(Patient's account).

"In a way that I cannot explain, I feel I am much better off for my stay in the sunroom".
(Patient's account).

"In the past, compared to now, my experience was really impoverished". (Patient's account).

In addition, the subjective impression of patients and staff on the wards to which patients went, was that they had been affected positively. They participated more emphatically in their programmes, and reported almost without exception that what had happened to them in the sunroom represented the most profound experience they had had in the hospital, if not the most positive or comfortable.

"Had I not been there I would have remained incomplete". (Patient's account).

"That I became self-centred, irresponsible and non-caring is obvious; the destructiveness of this is clear!" (Patient's account).

On looking back over our experience with this eight month programme, it seems clear that many patients who had remained stuck or plateaued in the hospital for many years had been affected in a significant way for the first time. In our opinion this more than justified the programme.

Why had this happened? We think that a clearer picture has emerged of the value of the patient as therapist. Intelligent patients had acquired an apparatus of jargon and professional compassion that slid on like a well-fitting glove. In the Compressed Encounter Therapy unit, this wore thread bare quickly to expose the raw illness underneath. Although decidedly not a pleasant experience, it seemed helpful. The patients who blew their cool, had their needs exposed to them in a sustained fashion, and the patients who saw the process, saw the process. We wondered if it was not the unadorned humanness of other patients that contributed most to producing changes in this unit. The crux of the programme appeared to be that it both forced and facilitated this exposure at certain points in group development. Deprivation of all the usual masks lead to a keen awareness in patients of the extent to which they depend on others to complete themselves.

It was also apparent that the programme could be improved in a number of ways. First, although the smaller size group functioned much better than groups of 16, 8 persons in a room 4 yards by 20 can avoid each other's "life space" with relative ease. What is worse, the risk of homicide increases as the numbers decrease, and for a number of reasons the architecture of the sunroom did not lend itself to rapid or effective outside intervention to prevent homicide.

Secondly, the number of distractions accessible to the sunroom patients was excessive, considering the

objective of total confrontation in a "here-and-now" situation. Patients could look out the windows, pull sweaters over their heads, play with buttons, watch and hear other patients in the yard or up the corridor. Meal times and betimes were full of extraneous interaction.

Perhaps most difficult of all was the problem of attendant and professional staff involvement. Attendants were dragged into conversations and individual and group fantasies, while professional staff monitored, tinkered, and provided convenient objects of worship and escape.

These shortcomings were tackled by building what has been called a Total Encounter Capsule. This special ultrasafe room 8 by 10 feet in size has been built with a large one-way mirror in the ceiling, through which attendant staff can observe around the clock. The unit accomodates up to 8 patients, and shields them continuously from anything other than the events taking place between them, for periods of days or weeks. That is, from admission to release from the capsule these patients see or hear no one besides themselves, and are never further away from one another than a few feet. The means to arrest any violent acting out are efficient within seconds, and a feeding system has been developed which eliminates any contact with persons outside the unit. This programme has been operating for just over a month now and our experience with the first three groups shows considerable promise.

In addition, because of the smaller sized groups, the absence of contact with other patients and staff, and the ease of total observation, systematic research becomes much more feasible. To this end, the hospital has been granted funds by a private foundation to support a two year research evaluation of this successor to our original Compressed Encounter Therapy.

With all our programmes in the Social Therapy Unit at Oak Ridge we are, largely of necessity, testing to the limit the concept of therapy without "experts". We make the assumptions that any human being can be the healing agent for himself and others, that many human beings will exercise this capacity -- given an appropriately designed setting -- and that all human beings must ultimately be the source of their own mutual salvation, given the increasing shortage of "experts".